

Policyholder name on Avera ID card: _____

Policy number on Avera ID card: _____

Name Change

From: _____ To: _____

Effective date: _____ Reason for name change: _____

Please check all that apply and complete the required information that follows:

Address Change due to moving and/or

Address Change for billing purposes (please send my invoice to):

Street address: _____

City: _____ State: _____ ZIP: _____

Effective date: _____

Phone Number Change

Home phone: _____ - _____ - _____ Work phone: _____ - _____ - _____

Effective date: _____

Termination of Coverage

Voluntary termination, reason for canceling policy: _____

Date of termination: _____ Terminations will be effective the first of the month following the termination date requested or the date this notice is received by Avera Health Plans, whichever is later.

Return policy, I am returning the policy within the 30-day, free-look period. If the policy has already become effective, please refund my premium and reverse the claim payments as if my policy was never purchased. Policy return date: _____

Notification of deceased policyholder. Date of death: _____

NOTE: Copy of death certificate is required in order to terminate the policy.

Contact name: _____ Relationship to deceased policyholder: _____

Contact's day phone: _____ - _____ - _____

By signing the Change Form, I acknowledge that all information provided on this Change Form is complete and accurate to the best of my knowledge. Avera Health Plans must receive this Change Form within 15 days of the signature date to process.

Policyholder Signature (Required): _____ **Date:** _____

Send completed form to us by:

Mail: Avera Health Plans
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221

Fax:
605-322-7383

If you have any questions, please call our Service Center toll-free **1-888-322-2115**, 8 a.m. to 5 p.m. CT, Monday through Friday.